		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018176

Facility Name: HERITAGE SQUARE

Address: 620 N. OTTAWA AVE. (Number) DIXON (City) 61021 (Zip Code)

County: LEE

Telephone Number: (815) 288-2251 **Fax #** (815) 288-6821

IDPA ID Number: 36-605435-7001

Date of Initial License for Current Owners: 11/08/74

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: S.E. MONTAVON C.A. WOLBER **Telephone Number:** (815) 288-2251

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 3/29/04 (Date)
(Type or Print Name) SYLVIA E. MONTAVON
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	25	Skilled (SNF)	25	9,125	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	85	Sheltered Care (SC)	85	31,025	5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,971	6,077		9,048	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		15,081		15,081	12
13	DD 16 OR LESS					13
14	TOTALS	2,971	21,158		24,129	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.10%

D. How many bed-hold days during this year were paid by Public Aid?
3 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/07/1974

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/21/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HERITAGE SQUARE # 0018176 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	195,031	16,289	2,148	213,468		213,468	(11,939)	201,529			1
2	Food Purchase		163,145		163,145		163,145	(8,769)	154,376			2
3	Housekeeping	80,654	10,450	3,065	94,169		94,169		94,169			3
4	Laundry	15,804	5,448		21,252		21,252		21,252			4
5	Heat and Other Utilities			90,875	90,875		90,875		90,875			5
6	Maintenance	59,159	29,779	9,718	98,656		98,656		98,656			6
7	Other (specify):*			2,914	2,914		2,914		2,914			7
8	**TOTAL General Services**	350,648	225,111	108,720	684,479		684,479	(20,708)	663,771			8
	B. Health Care and Programs											
9	Medical Director			1,650	1,650		1,650		1,650			9
10	Nursing and Medical Records	707,167	21,697	1,318	730,182		730,182		730,182			10
10a	Therapy	15,424		1,863	17,287		17,287		17,287			10a
11	Activities	73,381	1,986	3,058	78,425		78,425		78,425			11
12	Social Services	33,172	448	428	34,048		34,048		34,048			12
13	Nurse Aide Training											13
14	Program Transportation		980	1,202	2,182		2,182		2,182			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	829,144	25,111	9,519	863,774		863,774		863,774			16
	C. General Administration											
17	Administrative	76,060			76,060		76,060		76,060			17
18	Directors Fees											18
19	Professional Services			10,107	10,107		10,107		10,107			19
20	Dues, Fees, Subscriptions & Promotions			33,306	33,306		33,306	(27,503)	5,803			20
21	Clerical & General Office Expenses	94,161	11,350	19,152	124,663		124,663	(15,295)	109,368			21
22	Employee Benefits & Payroll Taxes			310,465	310,465		310,465		310,465			22
23	Inservice Training & Education			250	250		250		250			23
24	Travel and Seminar			1,853	1,853		1,853		1,853			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			80,157	80,157		80,157		80,157			26
27	Other (specify):*											27
28	**TOTAL General Administration**	170,221	11,350	455,290	636,861		636,861	(42,798)	594,063			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,350,013	261,572	573,529	2,185,114		2,185,114	(63,506)	2,121,608			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HERITAGE SQUARE #0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			112,477	112,477		112,477		112,477			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75	75		75	(422,708)	(422,633)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			112,552	112,552		112,552	(422,708)	(310,156)			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			13,687	13,687		13,687		13,687			43
44	**TOTAL Special Cost Centers**			13,687	13,687		13,687		13,687			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,350,013	261,572	699,768	2,311,353		2,311,353	(486,214)	1,825,139			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(20,708)	VA127		4
5	Telephone, TV & Radio in Resident Rooms	(11,329)	VC217		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(422,708)	VD327		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,966)	VC217		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,187)	VC207		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,316)	VC207		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (486,214)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (486,214)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

HERITAGE SQUARE

ID# 0018176

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HERITAGE SQUARE **#** 0018176 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HERITAGE SQUARE # 0018176 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	ANNUITY INTEREST		X	ANNUITY	ANNUAL		$	$			$ 75	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 75	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 75	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HERITAGE SQUARE COUNTY LEE

FACILITY IDPH LICENSE NUMBER 0018176

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,354 B. General Construction Type: Exterior BRICK Frame STEEL GIRDERS,ME Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

1. WARNER CAMPUS - 2 FREE STANDING BUILDINGS WHICH EQUALS 4 UNITS.
2. EACH OF THE ABOVE 4 UNITS EQUAL 1160 SQ. FT. EACH, PLUS GARAGE.
(ABOVE INFORMATION TAKEN FROM ARCHITECT PRINTS.)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:
Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	HOME FOR AGED	97,046	1963	$ 42,888	1
2				31,315	2
3	TOTALS	97,046		$ 74,203	3

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	113		1974	1974	$ 1,532,081	$ 38,302	40	$ 38,302	$	$ 1,120,431	4
5	110		1993	1993	1,100,199	27,505	40	27,505		288,802	5
6											6
7											7
8											8
	Improvement Type**										
9	OUTDOOR LIGHTS			1977	696		20			696	9
10	PATIO COVER			1980	3,729		10			3,729	10
11	STOREROOM SPRINKLER			1981	1,309		20			1,309	11
12	P.T. + RHAB. RM.			1985	18,461	728	18	728		18,461	12
13	L.L. ACT. (REASSIGNED B.SP.)			1985	3,229	161	19	161		3,068	13
14	SOC. SERVICE OFFICE			1988	1,319	63	20	63		1,049	14
15	ROOF (N. WING)			1988	11,450	396	15	396		11,450	15
16	ROOF (HCC WING)			1988	5,940	211	15	211		5,940	16
17	ASPHALT DRIVEWAY			1989	2,571	160	15	160		2,461	17
18	CEILING (HCC)			1989	1,557	97	15	97		1,492	18
19	PARKING LOT			1989	11,398	541	20	541		8,206	19
20	GUTTER + DOWNSPOUTS (S.WING)			1991	4,500	280	15	280		3,710	20
21	VINYL FLOOR COVERINGS (SHELTERED CARE)			1991	487		10			487	21
22	PLUMBING REPLACEMENT			1991	2,099	100	20	100		1,302	22
23	STORAGE SHED			1991	1,189	57	20	57		736	23
24	FIRE ALARM IMPROVEMENTS			1991	1,630	77	20	77		1,012	24
25	INTERCOM IMPROVEMENTS			1992	508	32	15	32		386	25
26	FIRE PROTECTION BEAMS			1993	1,380	36	10	36		1,380	26
27	WALL PAPERING			1993	2,927		5			2,927	27
28	CONCRETE WALK + DRIVEWAY			1993	6,008	374	15	374		4,255	28
29	LANDSCAPING (NEW WING)			1993	7,749	419	10	419		7,749	29
30	RESURFACE PARKING LOT			1993	17,716	1,102	15	1,102		12,204	30
31	GUTTERS + DOWNSPOUTS (N.WING)			1993	3,600	224	15	224		2,488	31
32	HEATING (HCC FLOOR)			1994	3,966	357	10	357		3,888	32
33	ELEVATOR SAFETY SHIELD			1994	1,250	113	10	113		1,164	33
34	CONCRETE WALK + BENCH PAD			1994	1,225	58	20	58		605	34
35	PAINTING FACIA OF BUILDING			1994	1,955		5			1,955	35
36	CONT'D ON PAGE 12-A										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LIFE SAFETY DOOR CLOSER (REPLACE)	1995	$ 4,432	$ 276	15	$ 276	$	$ 2,466	37
38	PATIO SIDEWALK (REPLACE)	1995	6,507	309	20	309		2,731	38
39	PAINT SOFFITS + FRAMES	1995	2,975		5			2,975	39
40	SOFFIT REPAIR (VINYL)	1995	4,100	195	20	195		1,723	40
41	NURSE OFFICE FLOOR + WALLS (FIRST FLOOR)	1996	761		5			761	41
42	PAINT AND PAPER (HCC, SC, BSM)	1996	4,887		5			4,887	42
43	ATTIC VENTILATION (S. WING IN S.C.)	1996	11,600	551	20	551		4,292	43
44	EXTERIOR WALLS + DRIVE	1996	3,809	181	20	181		1,408	44
45	N.E. OUTDOOR STORAGE SHED	1996	707	34	20	34		261	45
46	LIGHTING REPLACEMENT (ENERGY EFFICIENT)	1997	13,031	811	15	811		5,532	46
47	RADIANT HEAT PANELS (S.C.)	1998	19,894	1,791	10	1,791		10,709	47
48	BED BUMPER GUARDS (HCC)	1998	765	46	5	46		765	48
49	KITCHEN FIRE SYSTEM	1998	898	43	20	43		225	49
50	8 ATTIC EXHAUST FANS (S.C.)	1998	6,356	302	20	302		1,664	50
51	PAINTING	1999	11,227	1,796	5	1,796		9,766	51
52	DEPOSIT BLDG. EXTENS.	2000	2,346					2,346	52
53	GFI ELECTRICAL UPGRADES	2000	4,800	228	20	228		716	53
54	PAINT HALLS + DOORS	2001	5,970	955	5	955		3,005	54
55	NEW SOUTH ROOF	2002	171,935	5,731	30	5,731		7,164	55
56	NEW ROOF	2003	140,137	779	30	779		779	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,169,265	$ 85,421		$ 85,421	$	$ 1,577,517	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 518,466	$ 25,860	$ 25,860	$		$ 387,457	71
72	Current Year Purchases	10,789	1,196	1,196			1,196	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 529,255	$ 27,056	$ 27,056	$		$ 388,653	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRANSPORT	1993 OLDS WAGON	1993	$ 14,528	$	$	$		$ 14,528	76
77										77
78										78
79										79
80	TOTALS			$ 14,528	$	$	$		$ 14,528	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,787,251	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 112,477	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 112,477	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,980,698	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	RENTAL HOUSE 1992	$ 35,086	$ 974	$ 11,467	86
87	LAND	10,000			87
88					88
89					89
90					90
91	TOTALS	$ 45,086	$ 974	$ 11,467	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

WE HIRE CERTIFIED NURSES AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,221,930	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	52,168		3
4	Supply Inventory (priced at COST)	15,963		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,290,061	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	142,470		11
12	Long-Term Investments	893,701		12
13	Land	74,203		13
14	Buildings, at Historical Cost	3,169,267		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	543,780		16
17	Accumulated Depreciation (book methods)	(1,989,819)		17
18	Deferred Charges	5,167,849		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	492,998		21
22	Other Long-Term Assets (spe RENTAL	45,087		22
23	Other(specify): WARNER CAMPUS	188,305		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,727,841	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,017,902	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 31,480	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	104,280		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,977		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 143,737	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	GIFT ANNUITY	1,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 144,737	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,873,165	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,017,902	$	48

***(See instructions.)**

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,745,119	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,745,119	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	128,046	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 128,046	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,873,165	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,149,764	1
2	Discounts and Allowances for all Levels	(158,717)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,991,047	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	13,201	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 13,201	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	621	12
13	Barber and Beauty Care	1,374	13
14	Non-Patient Meals	7,448	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,445	17
18	Sale of Supplies to Non-Patients	1,483	18
19	Laboratory	2,636	19
20	Radiology and X-Ray		20
21	Other Medical Services	12,296	21
22	Laundry	29	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 27,332	23
	D. Non-Operating Revenue		
24	Contributions	24,721	24
25	Interest and Other Investment Income***	422,708	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 447,429	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	BENEFICIAL TRUST (LOSS)	(61,839)	28
28a	GAIN ON STOCK SALE	23,203	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (38,636)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,440,373	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	684,479	31
32	Health Care	863,774	32
33	General Administration	636,861	33
	B. Capital Expense		
34	Ownership	112,552	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	13,687	36
	D. Other Expenses (specify):		
37			37
38	(DEPRECIATION ON RENTAL PROPERTY ADJUSTED OUT	974	38
39	ON V-D-37-6)		39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,312,327	40
41	**Income before Income Taxes (line 30 minus line 40)****	128,046	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 128,046	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,994	2,200	$ 55,561	$ 25.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,523	8,124	141,774	17.45	3
4	Licensed Practical Nurses	12,643	13,336	197,782	14.83	4
5	Nurse Aides & Orderlies	29,436	31,441	312,050	9.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,461	1,628	15,424	9.47	8
9	Activity Director	1,924	2,080	27,046	13.00	9
10	Activity Assistants	4,356	4,671	46,335	9.92	10
11	Social Service Workers	2,444	2,727	33,172	12.16	11
12	Dietician					12
13	Food Service Supervisor	1,829	2,080	32,412	15.58	13
14	Head Cook	5,426	5,783	53,334	9.22	14
15	Cook Helpers/Assistants	12,481	13,200	86,986	6.59	15
16	Dishwashers	3,546	3,698	22,299	6.03	16
17	Maintenance Workers	4,472	4,899	59,159	12.08	17
18	Housekeepers	9,042	9,583	80,654	8.42	18
19	Laundry	2,313	2,526	15,804	6.26	19
20	Administrator	1,872	2,080	76,060	36.57	20
21	Assistant Administrator					21
22	Other Administrative	1,863	2,080	42,124	20.25	22
23	Office Manager	1,920	2,096	27,618	13.18	23
24	Clerical	3,582	3,833	24,419	6.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	110,127	118,065	$ 1,350,013 *	$ 11.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	CONTRACT	$ 2,148	V-A-1-3	35
36	Medical Director	CONTRACT	1,650	V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	32	1,168	V-B-10-3	39
40	Physical Therapy Consultant	27	1,863	V-B-10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	643	V-B-11-3	44
45	Social Service Consultant	8	428	V-B-12-3	45
46	Other(specify) CHAPLAIN	CONTRACT	1,950	V-B-11-3	46
47	Q.A. PHYSICIANS	6	150	V-B-10-3	47
48	SUNDAY CLERGY	31	465	V-B-11-3	48
49	TOTAL (lines 35 - 48)	116	$ 10,465		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SYLVIA E. MONTAVON	ADMINISTRATOR	0	$ 76,060
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,060

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CLIFTON GUNDERSON LLC	AUDIT	$ 9,800
CLIFTON GUNDERSON LLC	DATA PROCESS	2,120
EHRMANN GEHLBACH BADGER & LEE	ATTORNEY	187
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 12,107

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,823
Unemployment Compensation Insurance	11,006
FICA Taxes	102,524
Employee Health Insurance	165,388
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE PHYSICALS	990
EMPLOYEE VACCINATIONS	734
TOTAL (agree to Schedule V, line 22, col.8)	$ 310,465

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	504
Health Care Worker Background Check	60
(Indicate # of checks performed 5)	
LSN - AAHSA	3,226
CURRENT EVENTS&ASSN DUES INHAA	1,648
IL ACTIVITY PROF. DUES	140
ADMIN LICENSE & ANNUAL REPORT	105
INFECTION CONTROL MANUAL	120
CHAMBER,ROTARY,FESTIVAL	(818)
Less: Public Relations Expense	(976)
Non-allowable advertising	(23,393)
Yellow page advertising	(2,316)
TOTAL (agree to Sch. V, line 20, col. 8)	$ (21,700)

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	322
Seminar Expense	1,531
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,853

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	THE DOLLAR AMOUNT		$		$	$	$	$	$	$	$	$	$
2	INCLUDED IN SCH.												
3	V-6-3 IS THE TOTAL												
4	ACCUMULATION OF												
5	MINOR REPAIRS												
6	PERFORMED BY												
7	OUTSIDE CONTRACTORS												
8	IN 2003.												
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HERITAGE SQUARE # 0018176 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LIFE SERVICE NETWORK $3226

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 14.3

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 9,397 Line B-10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 13,687
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? YES Indicate the amount. $ 20,708

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 90%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTON GUNDERSON LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.